TWENTY-FIVE CONSECUTIVE

CASES OF OVARIOTOMY.

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A YEAR'S WORK IN OVARIOTOMY.[1]

BEING TWENTY-FIVE SUCCESSIVE CASES OPERATED UPON BETWEEN NOVEMBER 26, 1879, AND NOVEMBER 28, 1880.

BY JOHN HOMANS, M. D.

I PROPOSE to describe very briefly these cases, and make a few comments upon any points of clinical interest that I have observed.

DOUBLE OVARIOTOMY; DERMOID CYST OF RIGHT OVARY AND COMMENCING CYSTIC DEGENERATION OF LEFT OVARY; RECOVERY.

CASE XIX.[2] Anne S., aged twenty-four, was admitted to Carney Hospital November 19, 1879. The tumor had been discovered three months before, and had grown rapidly. The girth at the umbilical level was thirty-two inches. Her general health was good.

Antiseptic ovariotomy was performed on November 26th. The pedicle of the right ovary was tied in halves with carbolized silk after compression by Dawson's clamp, and that of the left was tied in the same manner without the use of the clamp. In the wall of the cyst were found pieces of skin with hair growing on them, a plate of bone about two inches square, and a sebaceous cyst. Microscopical examination by Dr. A. T. Cabot showed that the flat piece of bone was true bone. Recovery was rapid. Miss S. writes me on July 25, 1880: "I have been unwell five times in eight months; three times within the last three months just as regular as I ever was. At those times

[1] Read before the Boston Society for Medical Improvement.

[2] The numbers refer to the author's whole series.

I suffer more pain than I ever did before I was operated on." This fact has an important bearing on the usefulness of "Battey's operation." Both ovaries were, I think, thoroughly removed.

MULTILOCULAR CYST OF LEFT OVARY; RECOVERY.

CASE XX. Anna H., aged thirty-three, was operated upon December 21, 1879. Her general health had already begun to fail. The tumor had been discovered eight months before. Adhesions, broad and vascular, to the omentum and intestine were tied with silk or catgut, and then divided with Paquelin's thermocautery.

MULTILOCULAR CYST OF RIGHT OVARY; RECOVERY.

CASE XXI. Anne M. P., aged thirty-nine, was operated upon in her home in Boston on February 8, 1880. Her health was failing; she was confined to her bed, and had considerable œdema of her lower extremities. The tumor had been discovered five months before. There were no adhesions. Recovery was rapid.

CYST OF THE LEFT BROAD LIGAMENT; RECOVERY.

CASE XXII. The cyst was removed at the Carney Hospital on March 7, 1880. The umbilical girth was forty-three inches. The tumor had been known to exist for at least four years. Both ovaries were healthy. The fluid removed weighed twenty-six pounds and the cyst eleven ounces. Dr. A. T. Cabot reported that the fluid was slightly alkaline, sp. gr. 1005, and that it contained a small quantity of albumen and no mucin. She recovered quickly.

MULTILOCULAR CYST OF THE LEFT OVARY; RECOVERY.

CASE XXIII. Laura A. M., aged fifty-seven was operated upon in her home at Taunton, Mass., on

March 23, 1880. The tumor was discovered about six months before. The cyst was much degenerated, more or less rotten, and friable. The pedicle was secured as usual. Recovery was rapid.

CASE XXIV. Anne L. S., aged eighteen, was operated upon at Carney Hospital April 1, 1880. The tumor weighed forty-five pounds. The adhesions were universal and intimate to the anterior parietes, and were burnt off with Paquelin's cautery. The pedicle was secured first by Dawson's clamp, then it was perforated by a double ligature of carbolized silk, and tied in halves, and finally was divided by Paquelin's cautery; Dawson's clamp was then removed, and the stump allowed to fall back into the pelvis. This method of treating the pedicle I have followed ever since. Recovery was rapid; but the patient was somewhat annoyed by an abscess in the wound discharging through the tracts of the sutures. Possibly this suppuration was caused by the cautery, which was used freely near the wound.

UNILOCULAR CYST OF LEFT OVARY; RECOVERY.

CASE XXV. Mrs. C., aged forty-eight, was operated upon at her home in Fall River, Mass., April 17, 1880. There were no adhesions. The pedicle was secured as in the last case. Recovery was very rapid.

CASE XXVI. Hannah T., aged fifty-eight, was operated upon at Carney Hospital on April 29, 1880. There were no adhesions; the pedicle was secured as usual. Recovery was almost immediate, the temperature never rising above 99° F. nor the pulse above 97 beats per minute.

MULTILOCULAR CYST OF LEFT OVARY; RECOVERY.

CASE XXVII. Fannie O. D., aged thirty-eight, was operated upon in her home at Mt. Holly, Vt., on May 18, 1880. There were no adhesions. The pedicle was secured as usual. Recovery was rapid.

UNILOCULAR CYST OF LEFT OVARY; RECOVERY.

CASE XXVIII. T. W. N., aged fifty-seven, was operated upon in her home in Boston on July 10, 1880. The tumor weighed forty-eight pounds. There were no adhesions. Recovery was very rapid. The temperature never rose above 99.5° F., nor the pulse above 85 beats per minute.

CYST OF THE LEFT BROAD LIGAMENT; RECOVERY.

CASE XXIX. S. F. E., aged forty-seven, was operated upon at the Carney Hospital on July 15, 1880. There were no adhesions. The fluid, which was limpid and clear, weighed eighteen pounds, and the delicate unilocular cyst a few ounces. Recovery was rapid.

MULTILOCULAR CYST OF RIGHT OVARY; RECOVERY.

CASE XXX. Abbe B., aged forty-seven, was seen in her home July 26, 1880. She was unable to leave her bed, and was evidently suffering from peritonitis and a low form of inflammation within the peritoneal cavity. Her case was not a promising one, as she was a stout, flabby woman, who had worked hard until she had to give up. She was removed to the Carney Hospital, and ovariotomy was performed on July 31st. The adhesions were recent and intimate between every portion of the cyst and the omentum and intestines. The omentum was half an inch thick, of a purple color, and showed itself when the peritonæum was opened. On separating the omentum from the cyst, and turning the former upwards upon the exterior of the abdomen, the cyst was seen. It was of a darkish-brown color, and beginning to be gangrenous, degenerating and inflamed inside and out. The cystic fluid was brown and commencing to decompose. More or less reddish ascitic fluid ran out. Some of the adhesions were separated with the fingers and some with Paquelin's cautery. The pedicle, which was very short, was compressed, tied, and burnt off at about the distance of a line from

the intestine with which it was intimately incorporated. The temperature was 100.9° F. on the morning of the operation, and on the third day — that is, at the end of forty-eight hours — it had sunk to the normal level 98.5° F., and the pulse had fallen from 115 to 100. Recovery was rapid, and she went home at the end of two weeks. It may be asked, Why did this woman recover? Because her system was relieved of an exceedingly large mass undergoing decomposition and beginning to poison her blood, and the whole peritoneal cavity was washed clean. I should have said that the intestinal walls were velvety-looking and stiff like the right ventricle of the heart. The omentum was turned up and laid on a carbolized towel, and the intestines turned downwards on the pubes during the removal of the cyst. The cyst weighed two pounds, and the fluid eight and a half. The abdominal enlargement dated back about two years.

MULTILOCULAR CYST OF THE LEFT OVARY; RECOVERY.

Case XXXI. Emma H., aged thirty, was operated on at the Carney Hospital on August 1, 1880. There were no adhesions. The tumor weighed twenty-five pounds. Recovery was rapid.

Case XXXII. Sarah J. S., aged twenty-nine, was operated on at the Carney Hospital on August 21, 1880. The adhesions were recent and easily broken down. The walls of the cyst were made up of a sarcomatous-looking material, in many places half an inch thick. Dr. A. T. Cabot reported that the sarcomatous-looking appearances were villous growths, the tops of the villi growing together and inclosing little cavities, from the walls of which new villi grew. The tumor belongs to the class called villous or papillomatous. The tumor weighed twenty-three pounds. Of these papillomatous tumors and their subsequent history I have spoken at a former meeting of the society.[1]

[1] Vide Boston Medical and Surgical Journal, January 22, 1880.

MULTILOCULAR CYST OF LEFT OVARY; ASPIRATION OF CHEST; RECOVERY.

CASE XXXIII. Kate L., aged twenty-nine, was operated upon August 22, 1880, at the Carney Hospital. The tumor had been discovered about three months before. She had been tapped in May, and about three quarts of fluid drawn off. Her pulse was 104; her breathing was rather labored, and her left lower extremity was œdematous. Her umbilical girth was forty-three inches. The cyst and its contents weighed fifty pounds; inasmuch as the material was semi-solid, and would not flow through a trocar, the cyst was necessarily removed piecemeal. At the conclusion of the operation the patient was very feeble, and her recovery seemed quite doubtful. The pulse ranged from 130 to 140, and the temperature stood at 100° F., and gradually rose to 101° F. on the third day. On the morning of the fourth day a severe and distressing attack of dyspnœa came on, lasting several hours. On examination the whole of the left thoracic cavity was found to be perfectly flat, and filled with fluid. By the advice and with the assistance of Dr. D. H. Hayden forty ounces of serum were drawn out by aspiration. The patient became somewhat livid, and coughed considerably, but this gradually passed off, and improvement and absorption went on rapidly, until, on the seventh day, the temperature had fallen to the normal standard and the pulse to 110. After this convalescence was rapid, and she went home on the twenty-eighth day after ovariotomy. I have never known of a case of aspiration of the chest after ovariotomy. Had I known of the presence of this fluid in the thorax before the operation I am sure that I cannot tell what plans I should have made. I attributed the rapid respiration to the pressure of the tumor against the diaphragm and the probably œdematous condition of the lungs. The case was a very doubtful one, and one that I hesitated about and operated upon

somewhat reluctantly, but the issue was successful, and perhaps aspiration *after* the operation was better surgery than aspiration before.

MULTILOCULAR CYST OF THE RIGHT OVARY; DEATH.

CASE XXXIV. Caroline F., aged forty-six, was operated upon at her home in Woburn, September 1, 1880. The patient's abdomen, buttocks, thighs, and legs were greatly swollen, her abdominal parietes were several inches thick from œdematous swelling, and from the skin of the abdomen and the legs exuded serum, which ran from the bursting and eczematous cuticle. The patient was informed that I could give her no encouragement that the tumor could be removed, but as its contents would not flow through a trocar, and as her death was certain within a few weeks, an exploratory incision seemed a sensible thing to do. She decided to have this done. On opening the abdomen the tumor was found to be practically solid. An opening was made in the tumor with the cautery, and its size reduced as rapidly as possible; the adhesions were broken down, and the tumor removed. The relief to the patient was immense, and for forty-eight hours it seemed as if she would certainly recover; but the weather became excessively hot and sultry, and death took place from exhaustion on the fifth day. The tumor weighed thirty-nine pounds.

MULTILOCULAR CYST OF THE LEFT OVARY; RECOVERY.

CASE XXXV. Margaret K., aged forty-seven, was operated upon at Auburndale on September 2, 1880. The tumor weighed forty pounds. There were no adhesions. The wall of the cyst was as delicate as the membrane of the chorion, and when the peritonæum was divided a semi-solid material resembling calf's-foot jelly or vaseline burst through and flowed out. This was scooped out and squeezed out, and more or less was entangled in sponges and brought

out. The pedicle, which was very delicate and friable, was secured in the usual manner. Recovery was uninterrupted, and was due to the antiseptic precautions and to prolonged and patient sponging and wiping of the peritoneal cavity.

MULTILOCULAR CYST OF THE LEFT OVARY; DEATH.

CASE XXXVI. Lucy A., aged twenty-seven, was operated upon at the Carney Hospital on September 7, 1880. The diagnosis was a cyst of the left ovary, with more or less pelvic adhesions. The tumor was found to be intimately adherent to the intestines, uterus, and pelvic organs; its nourishment was mainly derived from the mesentery. It was almost impossible to tell where the outline of the bowel ended and that of the cyst began, and after patient efforts and considerable hæmorrhage all attempts to separate the outer covering of the cyst were abandoned, and it was enucleated, leaving its outer envelope attached to the intestine and uterus. The patient never rallied from the shock of the operation, and died in about fourteen hours. In structure the tumor was papillomatous.

MULTILOCULAR CYST OF LEFT OVARY; RECOVERY.

CASE XXXVII. Louisa F., aged thirty-three, was first seen at the Carney Hospital on September 9, 1880. On August 31st she had been tapped at her home in West Scituate by Dr. French, and thirty-five pounds of fluid had been removed. On September 9th I tapped and removed thirty pounds of fluid, partly ovarian and partly ascitic. On the 23d all œdema of the legs and abdomen had subsided, and the cyst was removed. The adhesions were recent and slight. The tumor and its contents weighed sixteen pounds. Recovery was rapid.

CASE XXXVIII. Sarah S., aged forty-eight, was operated upon October 2, 1880. Her case showed the advantages of preliminary tapping in certain cases, of which the previous one and this one are good in-

stances. Ten days before the operation her lower extremities and abdominal parietes were excessively œdematous, and she was tapped, so that by the time of the operation the œdema had greatly subsided and her condition was very good. The adhesions were new and old, and almost universal to the parietes. The tumor was largely solid. Recovery was uninterrupted.

MULTILOCULAR CYST OF THE RIGHT OVARY; RECOVERY.

CASE XXXIX. Rosa Z., aged thirty-eight, was first seen on June 15, 1880. As she was a Cuban, and could neither speak nor understand English, I was unable to convince her that removal of the cyst would be better than tapping, and as she had been told that the cyst might not fill up after tapping I consented to tap her, and removed thirty-seven pounds of chocolate-colored ovarian fluid. On October 6th ovariotomy was done at the Carney Hospital. The operation, I thought, would be a simple one, but solid and old adhesions united the cyst to the omentum and to the uterus and pelvis. The uterus was almost as much a part of the tumor as the interior cysts, and projected into the cyst wall so that its outline could be felt from the interior of the cyst. The outer membrane of the cyst was left upon the uterus and pelvis, and the cyst more or less enucleated. The pedicle was secured in several parts wherever there seemed to be a likelihood of hæmorrhage. Recovery was very rapid.

UNILOCULAR CYST OF THE LEFT OVARY; RECOVERY.

CASE XL. Sarah M., aged forty-five, was operated upon at the Carney Hospital on October 24, 1880. The tumor had been discovered six months before, and had apparently been burst in April by the patient's lying on her stomach. About three weeks after the discovery of the tumor Mrs. M., feeling uncomfortable, tried the experiment of turning over and lying on her

stomach. Immediately she felt something give way, and could no longer find the tumor. Vomiting came on, and she had great pain for twenty-four hours. No adhesions were set up, however. Recovery was sufficiently rapid, and she left the hospital on the twenty-first day.

In this case and in the one which followed there occurred a slight attack of phlegmasia dolens. On the twelfth day after ovariotomy the patient was feeling so well that she begged to sit up for a few minutes. She was allowed to do so, and walked a few steps to a sofa. On the next day she complained of pain in her hip and leg, and in a day or two the right leg measured about an inch more in circumference than the left. The temperature rose to 101.6° F., and did not sink to the normal height for a week. Now, January 5, 1881, although the patient has gained flesh and is feeling well, the right leg is somewhat larger than the left. The ovary that was removed was on the left side. There is still some swelling of the leg at the close of the day.

MULTILOCULAR DERMOID CYST OF THE LEFT OVARY; RECOVERY.

Case XLI. Mrs. S., aged thirty-one, was operated upon at the Carney Hospital on November 6, 1880. The presence of the tumor had been known for at least four years. The tumor weighed twenty-two pounds, and contained in one spot a mass of hair, epithelium, and bone or cartilage. Recovery was rapid, but was attended with the same swelling of the lower extremity as in Case XL. There has also been a slight feeling of soreness on deep pressure in the left iliac region. Mrs. S. was very anxious to leave the hospital, and seeming perfectly well she was allowed to ride home in a comfortable carriage on the nineteenth day after ovariotomy. Her ride tired her very much, and caused severe pain throughout the abdomen for about two hours after reaching home. Soon the same sort of in-

dolent swelling as in the last case took place, and now, January 1, 1881, still exists slightly; but the tenderness in the groin has entirely subsided, and the patient is gaining flesh, and looks and feels perfectly well.

MULTILOCULAR CYST OF THE RIGHT OVARY; RECOVERY.

Case XLII. C. W., aged thirty-one, was operated upon at the Carney Hospital on November 18, 1880. I had seen her at my office some weeks previously, and had thought her tumor probably uterine, with more or less ascites. She was much distressed in her mind and was quite worn and feeble. Her appetite was poor, she did not sleep well, her breathing was short, and she had coughed much for three weeks. Her pulse was rapid and feeble. My diagnosis was ascites, with a tumor more or less cystic and either uterine or ovarian; more probably the former, because the uterus and tumor were so intimately connected that the least motion communicated to the latter was transmitted at once to the former. On lifting the tumor the uterus was pulled upwards, on moving the tumor to one side the uterus was moved also, as if it were a part of the tumor. Finally, I said, "Whenever you feel that your life is a burden to you on account of this tumor, let me know, and I will try to remove it and cure you." It was not many weeks before she came and asked to have the operation attempted. The result showed that my diagnosis was wrong and that the tumor was ovarian. At the operation a portion of the cyst was found to be intimately adherent to the small intestine; this portion, about an inch and a half long and half an inch wide, was cut out and left on the intestine. In the pelvis there were practically two pedicles: one, the ordinary pedicle, comprised of the broad ligament and Fallopian tube, belonging to the right ovary, was secured as usual; the other consisted of a series of bands, in appearance resembling the cicatrized contracted bands of burns, such as one sees between the chin and sternum, for in-

stance. These bands, altogether about two inches broad, connected the uterus and the ovarian cyst intimately, and this connection it was which had conveyed the impression that the tumor was a growth from the uterus. I secured these adhesions in an écraseur, and divided them with Paquelin's cautery. The patient went on very well until the twelfth day, when she had nose-bleed, and on the next day a hæmorrhage that seemed to me to come from the lungs. She went home perfectly well on the twenty-seventh day after ovariotomy.

Case XLIII. C. A., aged fifty-two, was operated upon at the Carney Hospital on November 28, 1880. A fortnight before she had entered the hospital, but in such a state of alcoholismus that the operation was deferred until her condition became more natural. The pedicle was extremely thick and several inches broad, so much so that it was difficult to include it in a Dawson's clamp, and when burned off and tied presented a stump as thick as my wrist. The only adhesion was a broad and intimate one to the uterus. The tumor weighed twenty-nine pounds. Her recovery was very satisfactory; her temperature never being above 99° F., except on the evenings of the second and third days, when it stood at 100.8° F. and 100° F. respectively.

These cases, so far as they go, are a proof of the great value of the antiseptic method, or Listerism. I like this latter name because it is concise and identifies Lister's name with the magnificent principle which he has discovered and the method which he has introduced. The number of cases is small, but I am very sure that the percentage of recoveries is much higher than it would have been without Listerism, and the ratio is about what may be expected in cases done antiseptically by an experienced operator. So much has been written and said about the diagnosis of ovarian tumors and the method of performing ovariotomy that any remarks on these subjects would be out of place and superfluous. Any one wishing to know what can be ac-

complished by experienced operators, practicing *perfect* attention to all the details of cleanliness, *without* the spray, is referred to the writings of Mr. Wells and Dr. Keith.[1]

A MORAL DUTY OF THE OVARIOTOMIST.

I think there is a moral duty involved in undertaking to practice ovariotomy, namely, that a surgeon is bound at times to operate in cases where he can give but little hope for a favorable result. This becomes more and more a duty as time goes on and the operation becomes more and more firmly established. In the earlier efforts to make the operation one to be advised and urged, it would have been wise to select for operation only those cases almost certain to recover, in order that ovariotomy might not fall into disrepute, but now I think an ovariotomist ought to be willing to operate in a case like Number XXXIV., for instance, where the contents of the tumor were so thick that they could only be removed through an incision which would admit the hand. Here there was a possibility of recovery and a certainty of a speedy and distressing death. Much precious time had been lost in this case on account of the supposed existence of pregnancy, but after a lapse of a year without parturition it was found that the tumor was ovarian. In this case, if the fluid had been limpid, the patient ought to have been tapped, and probably when her œdema and general dropsy had subsided ovariotomy would have been successful.

THE PERSISTENCE OF MENSTRUATION AFTER DOUBLE OVARIOTOMY.

This is illustrated in Case XIX. Miss S. states in a letter lately received: "To-day [November 26th] is the anniversary of my operation. I have gained seventeen pounds in the year, and have been unwell *reg-*

[1] Dr. Keith's article on Ovariotomy before and since the Introduction of Antiseptics, in the British Medical Journal for October 19, 1878, will well repay perusal.

ularly for the last eight months. I suffer very much pain at those periods." In a previous letter she writes that her menstrual periods have been very painful since the removal of the ovaries, — much more so than before. Now it is *possible* that there may be a third ovary, or that some of the ovarian substance containing ova may have been left; but neither of these conditions is probable, and a ligatured stump of an ovary is not at all likely to be able to discharge ova through its tied and cicatrized surface. So far as this case goes it would not encourage one to perform Battey's operation in order to bring about the menopause.

PAIN AFTER OVARIOTOMY.

In regard to pain after ovariotomy patients vary very much: some have very severe pain at a single point in the small of the back, and some complain only of a slight feeling of soreness. Almost every patient requires an opiate, at least once. Some are much distended with wind and suffer in consequence, while in others the intestines remain collapsed, and we find the same deep hole, filled with wrinkled and superfluous skin, when we remove the stitches a week after the operation, that was left when the wound was sewed up; so remarkable is this sometimes that the integument has to be unrolled and unfolded to find the line of incision. This presence or absence of pain, or distention or flatness, seems to have no relation to the amount of handling the peritonæum has undergone.

FLOWING AFTER OVARIOTOMY.

A moderate amount of hæmorrhage from the uterus is not very unfrequent after ovariotomy, and is, as far as I know, of no especial importance.

TEMPERATURE AFTER OVARIOTOMY.

The bodily temperature after this operation and during convalescence is generally low. I mean lower than

one would naturally expect; it often does not rise to 100° F., and seldom reaches 101° F.[1]

PRELIMINARY TAPPING.

Tapping before ovariotomy, except for purposes of diagnosis or to remove œdema, is an evil, because it sometimes gives rise to adhesions, or causes more or less suffering and pain.

The lady whose case is described in No. XXVII. writes to me: "Advise your patients never to be tapped. I suffered more after tapping than I did after the operation." Mr. Wells has shown, however, that ovariotomy in a large number of cases is as successful in those who have been tapped as in those who have not. The emptying of a cyst by the slow process of aspiration is a most pernicious practice and quite harmful, while simple tapping with a good-sized trocar is almost in comparison innocuous. The attempt to completely empty a cyst in this way seems (at least in my experience) to be followed by a complete degeneration and softening of the contents of the sac and a deposit of a layer of friable lymph on its inner wall. This condition of things can generally be inferred from the pain and constitutional irritation that the patient suffers. Tapping before ovariotomy is always necessary in such cases as XXXVII. and XXXVIII., where there is great œdema of the abdominal walls and lower extremities. If, after the tapping, the patient's general condition markedly improves and the œdema subsides, you may hope for the best results from ovariotomy.

ASPIRATION OF THE CHEST FOR PLEURITIC EFFUSION AFTER OVARIOTOMY.

Case XXXIII. is unique, so far as I know, in regard to the tapping of the chest for pleuritic effusion on the fourth day after ovariotomy. I cannot say whether

[1] In the British Medical Journal for December 18, 1880, will be found an interesting discussion on hyperpyrexia after Listerian ovariotomy at the Royal Medical and Chirurgical Society.

there was fluid in the chest before the operation, but had I known that there was I should have inferred that it was a part of the general dropsy, and that it would be absorbed rapidly after the removal of the tumor, just as œdema of the legs generally disappears entirely within four days after ovariotomy.

PHLEGMASIA DOLENS AFTER OVARIOTOMY.

Cases XL. and XLI. illustrate the rare occurrence of a mild form of phlegmasia dolens after ovariotomy. When this occurs the extremity on the opposite side to that from which the ovary was removed seems more likely to be affected than the one on which the pedicle has been tied; or, to speak more carefully, it has been found in four cases in which this complication has occurred that three were on the side opposite to the pedicle and one on the same side. In the *American Journal of the Medical Sciences* for July, 1880, Dr. Walter F. Atlee, of Philadelphia, relates a case of ovariotomy in which phlegmasia dolens followed the operation. Dr. Atlee remarks, "This complication of the operation for the removal of an ovarian cyst I had never before seen or heard of." He quotes a like case reported by Dr. Galabin, of Guy's Hospital, in the *British Medical Journal* of March 13th. Both of my cases were very mild, though tedious. The cause of this inflammation of the vein is not at all apparent. Dr. Galabin has no theory to offer, and Dr. Atlee is inclined to think that the cause was septic. In my cases walking about seems to have lighted up the trouble, but exactly why it should in these cases and not in others I am unable to explain.

HÆMOPTYSIS AFTER OVARIOTOMY.

I do not remember to have read any account of the occurrence of hæmorrhage from the nose and lungs after ovariotomy, such as occurred in Case XLII. Whether this hæmorrhage was salutary and was similar to the hæmorrhages from the uterus, which I have

mentioned above, or whether it was accidental and entirely unconnected with the operation and the precursor of phthisis, I cannot decide, but the future career of the patient will be interesting to follow.

PAPILLOMA OF THE OVARY.

I will merely repeat what I said in this room a year ago in regard to these tumors : "It is difficult, for me at least, to classify some of the almost solid cystic tumors of the ovary, that is, whether to call them cancerous or not, but there is a class of malignant tumors which I have removed three times. I refer to the papillomatous or 'warty-looking' ovarian tumor. These tumors usually burst through their enveloping cyst wall early in their career, and the cystic fluid poured out sets up an ascites, so that at the operation you have generally more ascitic than cystic fluid. These tumors stand up like cauliflowers, and involve, sooner or later, both ovaries. Soon after recovery from ovariotomy, in one of these papillomatous cases, a new growth takes place in the other ovary and in the peritonæum and other organs, and the patient dies within six months. Such cases are spared much suffering, and sometimes enjoy a few weeks of health ; however, as a general rule their recovery is not rapid, and their subsequent decline in health takes place before its reëstablishment is completed. But little is said in the books to which I have had access, and yet I have met with five cases in forty-three ovariotomies."

TIME OF LEAVING HOSPITAL AFTER OPERATION.

Patients generally are ready to leave the hospital at the end of the third week after the operation ; some leave sooner and some remain later. I think that most of the favorable cases are able to go home at the end of three weeks.

There are certain details of the operation and general rules that may be worth mentioning. Always clean up as thoroughly as you can a dirty, inflamed

peritoneal cavity. I always do this, and have several times wiped masses of lymph off from the intestines and peritonæum; perhaps this latter action is unnecessary, but the patients have recovered, and I have not regretted doing it. I generally cut out and leave behind any portion of the cyst intimately adherent to a coil of intestine; it is better to do this than to run the risk of rupturing the bowel or causing hæmorrhage from its surface, which it is not easy to control. I have always followed Mr. Spencer Wells's advice not to yield to the temptation to remove a fibroid from the uterus during an ovariotomy; the desire to do so is very strong, but I think the safer way is to leave them alone, and, although I have once or twice seen them well pediculated, I have not meddled with them. I always compress the pedicle with Dawson's clamp (a very simple and powerful instrument which has done me good service), then burn off the pedicle with Paquelin's cautery, tie with a double ligature (*in the sulcus made by the clamp*), remove the clamp, and drop the stump. I do this because two of the most successful operators, Drs. Keith and Bradford, have used one the cautery and the other the ligature, and so I use both. I dare say that either would be sufficient, but I see no objection to my method, and am satisfied with it. I never use catgut for tying the pedicle, but always carbolized silk. I lost a case from hæmorrhage after tying with catgut, and have never used it since. So far as my experience has gone, abdominal hernia rarely occurs after ovariotomy unless the patient is very careless. Mr. Wells advises that the abdomen be supported by adhesive plaster for six weeks after the operation, and that a proper abdominal belt be worn for at least a year. In the only cases I have known the patients were ignorant and careless, and took off all support, and worked hard within a few weeks after recovery.[1] I continue to find my operating table, which I have shown at one of the society's meetings, very convenient. I can

[1] Boston Medical and Surgical Journal, March 6, 1880.

turn a patient nearly over without having the least anxiety as to her slipping off the table, while the board is securely held at any angle by the ratchet or pall in the cogwheel. I have declined to operate but in a single case during the last year, — a case of malignant disease with marked cachexia. This case was operated upon by another physician, but the result was fatal.

OPERATING TABLE.[1]

I will quote again from the records of the society to describe the operating table mentioned above.

"Dr. Homans also exhibited an operating table for ovariotomy, and said that it was sometimes desirable during an ovariotomy to turn a patient more or less completely on her side. This becomes necessary when the cyst is very friable, or has been ruptured since the operation was begun, and consequently there is great difficulty in keeping the cystic fluid from running into the abdominal cavity. With the patient on her back, any fluid that may be leaking around the clamp or running out from a laceration in the cyst gravitates into the abdominal cavity; the operator then calls upon his assistants or some of the spectators to turn the patient towards him. Now, however willing and strong the assistants may be, there is a slight feeling of uncertainty as to whether one of them may not become fatigued, and allow the patient to slip or fall back. A patient placed on this board, which is eighteen inches wide and has an iron trunnion or axle at either end, like the trunnions of a cannon, is securely strapped thereto, and when it becomes necessary to turn her, the board, with her on it, is rotated by means of a lever attached to a cog-wheel, and by dropping the pall the patient may be kept as long as desirable in any position and at any angle. These little tables support the board at either end, and when not in use fold up. There are two dowel-pins beneath the table at either end, which drop into holes in the tables, and thus

[1] Boston Medical and Surgical Journal, May 6, 1880.

CASES OF OVARIOTOMY FROM NOVEMBER 26, 1879, TO NOVEMBER 28, 1880.

No.	Date.	Place of Operation.	Condition.	Age.	Length of Incision.	Adhesions.	Treatment of Pedicle.	Weight of Tumor.	Result.	Remarks.
1	Nov. 26, 1879.	Carney Hosp.	S.	24	6 in.	Slight.	Tied with carbol. silk and dropped back.	12 lbs.	Recovery.	Both ovaries removed. Menstruation regular, but more painful than before ovariotomy. One cyst dermoid.
2	Dec. 21, 1878.	Do.	S.	33	4 in.	Omental and intes.	Do.	25 lbs.	Recovery.	
3	Feb. 8, 1880.	Boston.	M.	39	4 in.	None.	Do.	25 lbs.	Recovery.	
4	March 7, 1880.	Carney Hosp.	M.	28	3 in.	None.	Do.	27 lbs.	Recovery	Cyst of the left broad ligament.
5	March 23, 1880.	Taunton.	M.	37	3½ in.	Slight.	Do.	20 lbs.	Recovery.	
6	April 1, 1880.	Carney Hosp	S.	18	5 in.	Universal and intimate to anterior parietes, and slight to omentum.	Tied as above, and burnt off with Paquelin's cautery.	45 lbs.	Recovery.	Adhesions burnt off with Paquelin's cautery.
7	April 17, 1880.	Fall River.	M.	48	3 in.	None.	Do.	8¾ lbs.	Recovery.	
8	April 29, 1880.	Carney Hosp	S.	58	2½ in.	None.	Do.	14 lbs.	Recovery.	
9	May 18, 1880.	Mt. Holly, Vt.	M.	38	3½ in.	None.	Do.	50 lbs.	Recovery.	
10	July 19, 1880	Boston.	M.	57	4 in.	None.	Do.	48 lbs.	Recovery.	
11	July 15, 1880.	Carney Hosp.	S.	47	4 in.	None.	Do.	18 lbs.	Recovery.	Cyst of left broad ligament.
12	July 31, 1880.	Do.	M.	47	6 in.	Intimate, and recent to omentum and intestines.	Do.	11 lbs.	Recovery.	The omentum turned up and laid on a carbonized towel, and the intestines turned downwards towards the pubes during the removal of the cyst.

13	Aug. 1, 1880.	Do.	M.	30	3½ in	None.	Do.	25 lbs.	Recovery.	Dermoid cyst.
14	Aug. 21, 1880.	Do.	M.	29	6 in.	Almost universal and recent to parietal peritonæum.	Do.	23 lbs.	Recovery.	Papilloma.
15	Aug. 22, 1880.	Do.	M.	29	6 in.	Slight.	Do.	51 lbs	Recovery.	Forty ounces of serum removed by aspiration from the left thoracic cavity on the fourth day after ovariotomy.
16	Sept. 1, 1880.	Woburn, Mass.	M.	46	8 in.	To peritonæum, small intestine, and diaphragm; firm and old.	Do.	39 lbs.	Death.	Exhaustion on fifth day. Very hot weather.
17	Sept. 2, 1880.	Auburndale.	M.	47	7 in.	None.	Do.	40 lbs.	Recovery.	Fluid gelatinous.
18	Sept. 7, 1880.	Carney Hosp.	M.	27	6 in.	Intimate and old, or congenital, to small intestine, mesentery, and uterus; in fact, incorporated with them.	Do.	20 lbs.	Death.	Shock. Papilloma.
19	Sept. 23, 1880	Do.	M.	33	4 in.	Recent to anterior peritonæum.	Do.	16 lbs.	Recovery.	Sixty-five pounds of ascitic and ovarian fluid removed by tapping within the last three weeks before operation.
20	Oct. 2, 1880.	Do.	S.	48	5 in.	Universal, old and new, to peritonæum.	Do.	38 lbs.		
21	Oct. 6, 1880.	Do.	W.	38	3½ in.	Solid, old, to uterus, oment., and pelv.	Do.	15¼ lbs.	Recovery.	Cyst more or less enucleated.
22	Oct. 23, 1880	Do.	M.	45	2½ in.	None.	Do.	10½ lbs.	Recovery.	
23	Nov. 6, 1880	Do	W.	31	2½ in.	None.	Do.	21¼ lbs.	Recovery.	
24	Nov. 18, 1880.	Do.	S.	31	6 in.	To intestine and uterus.	Do.	18 lbs	Recovery.	The portion of the cyst adherent to bowels was cut out and left behind.
25	Nov 28, 1880	Do.	W.	52	3 in.	Do.	Do.	30 lbs.	Recovery.	

prevent the board from slipping. When the operation is finished the board is lifted out of its sockets at either end, and the patient is carried to her bed. This new operating table will probably soon be described more at length, with explanatory drawings."

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